MINUTES
of the
SECOND MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

July 17-18, 2017
Roswell Museum and Art Center
100 West Eleventh Street
Roswell

The second meeting for the 2017 interim of the Legislative Health and Human Services Committee was called to order on July 17, 2017 by Representative Deborah A. Armstrong, chair, at 9:16 a.m. in Bassett Auditorium of the Roswell Museum and Art Center.

Present
Rep. Deborah A. Armstrong, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Gail Armstrong
Rep. Rebecca Dow
Sen. Mark Moores
Sen. Howie C. Morales (7/17)
Sen. Bill B. O'Neill
Rep. Elizabeth "Liz" Thomson

Absent
Sen. Cliff R. Pirtle

Advisory Members
Rep. Joanne J. Ferrary
Sen. Gay G. Kernan (7/17)
Rep. Tim D. Lewis
Sen. Linda M. Lopez (7/17)
Sen. Cisco McSorley (7/17)
Sen. Nancy Rodriguez
Rep. Angelica Rubio
Sen. William P. Soules
Sen. Elizabeth "Liz" Stefanics
Rep. Christine Trujillo
Rep. Miguel P. Garcia
Rep. Rodolpho "Rudy" S. Martinez
Sen. Mary Kay Papen
Rep. Patricia Roybal Caballero
Rep. Nick L. Salazar
Sen. Bill Tallman

(Attendance dates are noted for members who did not attend the entire meeting.)

Staff
Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Karen Wells, Contract Staff, LCS

Monday, July 17

Representative Deborah A. Armstrong offered welcoming remarks. Members introduced themselves.

Welcome to Roswell: Health Update

Dennis J. Kintigh, mayor of Roswell, welcomed the committee members to the city. He highlighted the health care needs and available health care resources in the city, beginning with a great need for additional providers. He has established a committee to address this serious issue. Roswell, as a rural community, is especially challenged in recruiting providers. He called upon the University of New Mexico (UNM) Health Sciences Center (HSC) and the legislature to focus on expanding rural residencies.

Committee members had questions and comments, including the following:

- whether steps have already been taken to increase residencies in rural New Mexico; funding is limited for this purpose;
- a statement of commitment to work with UNM HSC to explore opportunities;
- a request to inform the committee at some point about the challenges and requirements in establishing residencies;
- whether telemedicine is being utilized in Roswell and how; and
- the importance of providing and funding trauma and emergency response statewide.

Approval of Minutes

There being a quorum, Representative Deborah A. Armstrong requested action to approve the minutes of the organizational meeting, as distributed. A motion to approve was moved, seconded and approved without objection. She identified some changes to the work plan and informed the members that Senator Pirtle has been added as a voting member.

New Mexico Medical Insurance Pool (NMMIP) Status Update

The chair began by recognizing the late Patty Jennings as the founder of the high-risk pool in New Mexico, with Roswell as its original home. She provided a brief history of the beginnings of the pool, which is now in its thirtieth year of operation. The pool has two primary purposes: to provide insurance to individuals who are otherwise uninsurable and to help stabilize the health insurance market in the state. The NMMIP is now the largest high-risk pool in the country. Representative Deborah A. Armstrong reviewed information and data about the NMMIP with the committee, including organizational structure, funding mechanisms, the growth of the pool over its history, demographics regarding enrollees, eligibility requirements and premium rates. Unique aspects of the NMMIP include a low-income premium program and a carrier assessment based in part on Medicaid business. An important NMMIP program is a Medicare carve-out program for individuals who qualify for Medicare but who are under the age of 65 and are thereby ineligible for Medicare supplement plans. The NMMIP is the only option for coverage for many of these individuals. The NMMIP has conducted a deliberately slow

transition of participants out of the pool and into the health insurance exchange, pursuant to the federal Patient Protection and Affordable Care Act (PPACA) implementation, to minimize disruption to the market. A separate handout provided many statistics, giving members a more detailed view of the benefits and services provided by the pool, as well as trends in eligibility, utilization and costs.

Questions and comments from the committee addressed the following issues:

- the number of states still involved in risk pools and why New Mexico retained its pool; states (including New Mexico) that cover the under-65 Medicare population tended to retain their pools;
- identification of populations not eligible for coverage under the PPACA and who are enrolled in the pool, in addition to the under-65 population who are Medicare eligible; participants include undocumented workers and some high-risk children; the Department of Health (DOH) subsidized some premiums, but most enrollees pay premiums, co-pays and deductibles;
- clarification regarding covered services;
- clarification regarding the impact and mechanism of premium tax credits; there is no General Fund impact of the pool; the cost to the state is in lost revenue due to premium tax credits;
- the estimated percentage of residents who need pool services but are not benefiting; probably a small percentage, as most hospitals can and do steer eligible folks to the pool;
- whether analysis has been conducted of the impact of current national health care reform proposals on pool enrollees and others who might need pool services in the future; most proposals anticipate using high-risk pools going forward but are underfunded; additionally, any reductions to Medicaid eligibility would result in increases in need for (unfunded) access to the NMMIP;
- an acknowledgment that, initially, many members of the pool were not high risk but were uninsurable; most of them were able to be served by the health insurance exchange; those who remain in the pool are very high risk;
- clarification of the distribution and percentages of total costs per enrollee and administrative costs;
- a request for a breakdown of contractor costs for administration of the NMMIP and whether there is redundancy in funding; each contractor has different and essential responsibilities; and
- clarification regarding the method and safeguards by which premium tax credits are determined.

Public Comment

Lisa Rossignol, UNM Center for Development and Disability, stated that the center is working with the Human Services Department (HSD) to improve Medicaid waiver revisions for children with special health care needs and to make sure the developmental disabilities waiver in

New Mexico is adequately serving them. There is a special need for enhancements to respite services. Potential carve-outs for special populations have to recognize a need for workforce development. Current waiver renewal drafts and concept papers have not been shared with advocates.

Lee Sipes attested to a concern about the inadequacy of the Medicaid waiver renewal, especially with regard to physical therapy, and the fear that this service will be eliminated in the future. This would be an incredible hardship for her husband.

Jamie Thornton advocated for continued coverage for children under Medicaid. She personally benefited from Medicaid when she was a child.

Former Senator Tim Jennings thanked the members for coming to Roswell. He encouraged the committee to communicate with New Mexico's congressional delegation regarding the needs of high-risk populations, the expected cost of their care and the need to adequately fund this in national health care reform efforts. He raised concerns regarding the costs of airlifting patients out of rural New Mexico to neighboring states when needs cannot be met locally. He stated that there is a great need to recruit physicians and other providers to rural areas of the state. He spoke to the need to rebuild behavioral health services and rehabilitation services statewide.

Joan Sanford, New Mexico Religious Coalition for Reproductive Choice, spoke to the potential damage that the proposed changes to the state Medicaid waiver will cause.

Marty Everett, administrator, La Casa Behavioral Health, described the struggle his organization is facing due to a 27% increase in insurance premiums for the business. Employees are unable to bear the burden of this level of increase.

After a lunch break, the chair asked members to reintroduce themselves.

New Mexico Health Insurance Exchange (NMHIX) Update

David Shaw, NMHIX Board of Directors, and chief executive officer, Nor-Lea Hospital District, Lovington, New Mexico, introduced Cheryl Gardner, chief executive officer, NMHIX, who gave a brief description of her experience working with exchanges since 2007. She provided an update on the status of the NMHIX and identified several different models of exchanges around the country. New Mexico adopted the Small Business Health Options Program (SHOP) Marketplace and uses the federal government exchange for individuals. This year, New Mexico will host an abbreviated open enrollment period, from November 1 through December 15. She described the process for managing the open enrollment process, which will involve a "warm handoff" to a broker for those who seek to utilize the exchange for insurance coverage. Ms. Gardner described campaign objectives and outreach goals and said the approach will be more personal and targeted than in the past.

Ms. Gardner addressed ways in which the NMHIX is trying to prepare for whatever form health care reform ultimately takes at the federal level. If enrollment in the NMHIX goes down, it will not signify a reduction in efforts to enroll people; the exchange is an administrative mechanism that helps people get enrolled. Ms. Gardner stated that she anticipates the NMHIX will still exist for the foreseeable future. Though she does not think that the current version of health care reform will pass the U.S. Congress, Ms. Gardner indicated that she does anticipate a stronger role for states in the management of health insurance coverage. Section 1332 of the PPACA allows states to opt out of the PPACA with certain limitations and conditions. Ms. Gardner is beginning to see more states pursuing Section 1332 waivers.

Committee members had questions and made comments regarding the following:

- possible changes the board is considering to respond to future uncertainty; the board plans to conduct statewide surveys and data collection to be clearer about coverage preferences and needs;
- the need to be more active with navigators in the community versus relying on the enrollment centers; work is being done to present a budget to the board that will permit this more aggressive outreach approach;
- the potential impact of anticipated increases in federal exchange fees to utilize external technologies for fiscal year 2018; work is being done to explore the feasibility of New Mexico operating its own exchange for coverage of individuals and for assuming all costs of operating the NMHIX, including technology;
- a description of how fees are assessed to insurers; fees are based on market share;
- clarification regarding educational efforts that are planned for NMHIX board members; the NMHIX is willing to share materials and handouts with the committee; additionally, invitations to meetings will be distributed;
- whether there are opportunities to mirror onsite Medicaid enrollment to enroll people in the NMHIX; some elements of that approach, including greater use of financial counseling at hospitals, are possible and are being explored;
- the impact of the exchange on hospital revenue cycles; use of the exchange has reduced uncompensated care in hospitals and has provided dignity to patients seeking care;
- the key impact of proposed health care reform approaches on New Mexico hospitals; no proposal so far restores the voluntary cuts hospitals agreed to in order to reduce the number of people uninsured under the PPACA; if those cuts remain, all hospitals in New Mexico will be severely impacted by revenue losses;
- why the enrollment window is shorter this year; it was a federal decision; the NMHIX had no input into that decision;
- whether there has been discussion regarding the impact of the potential elimination of the Medicaid expansion population; this has not happened yet, but the Office of Superintendent of Insurance (OSI) may be looking at it;
- a request for more specifics regarding the targeted population and the surveys that are planned; this is under development now; the NMHIX is seeking to identify reasons

people are still uninsured and to identify opportunities for efficiencies in the future; and

- whether there is any consideration for increasing the SHOP Marketplace employee limit beyond 50; yes, including the option of using a Section 1332 waiver to do so.

OSI Health Insurance Regulatory Update: Proposed Network Adequacy Rules; Surprise Billing; and Consumer Assistance Programs

Paige Duhamel, health care policy manager, OSI, testified about the process for handling consumer complaints, grievance procedures, standard versus expedited initial determinations, adverse determinations and appeals. Utilization review measures and processes were presented. Ms. Duhamel discussed the purpose of the OSI's Managed Health Care Bureau and provided a written summary of grievance procedures.

Jane Wishner, senior research associate, Health Policy Center, the Urban Institute, provided information about the Urban Institute and the Health Policy Center of the institute, of which she is a part. She highlighted research initiatives accomplished by the Urban Institute. Her presentation focused on what it takes to have an adequate provider network in a health plan, beginning with a brief history of how and why the government became involved in this area. Different types of regulatory approaches, including qualitative standards, quantitative standards and a mix of both, were described. Some states have different standards for monitoring and enforcing network adequacy regulations, but efforts are limited by available resources. Ms. Wishner touched on what network adequacy means with regard to Medicaid versus the private insurance market. She identified some emerging trends in network adequacy regulation and offered personal observations and ongoing challenges in attempting to ensure network adequacy. She recognized challenges that arise from consumers' lack of understanding about network adequacy and what their insurance policies do or do not cover. A lack of consumer awareness can lead to surprise billing, Ms. Duhamel explained. States around the country are trying to identify appropriate remedies for surprise billing.

Efforts are under way to better align private insurance, Medicare and Medicaid network adequacy standards nationwide and in some individual states. More work is needed in states to standardize the wide variety of regulatory approaches to network adequacy. More consumer education is essential, according to Ms. Duhamel. Work to fully understand the number of available providers statewide is critical. Regional planning efforts to assess needs and promote better integration of health care centers will help address these serious challenges.

Harvey Licht, consultant, rural health care, Varela Consulting Group, is currently engaged in working on network adequacy in New Mexico. Availability, affordability and acceptability are the three legs of the stool that make up network adequacy. The concept of network adequacy really began with the emergence of managed care organizations and requirements for them to ensure statewide access to their services. Over the years, however, many changes in health care delivery and workforce shortages have influenced understanding about what adequate access actually means. Regulation is important, but other approaches are needed. Four essential

elements are: standard setting; monitoring and performance assessment; compliance and enforcement; and network development. It is in this last element that legislation is vital.

Ms. Duhamel identified that consumer concerns about the inability to get needed care are a big issue in New Mexico. Another adequacy issue for the OSI is the ability or inability to ensure adequate coverage for everyone in the state, when insurance companies may not be able to meet the need in very rural locations. Different standards are often necessary based on the rural or frontier nature of the counties. In many of these communities, providers are being counted multiple times by different carriers to indicate compliance with requirements to demonstrate statewide access. Many states are moving to more standardized reporting. The OSI, on a yearly basis, requires carriers to report details on how they achieve statewide coverage. It actively engages with carriers when inadequacies are identified. The OSI recognizes that the issue is very complex and that carriers do not always have the ability to control information they receive from providers. Proposed regulatory changes are in the comment period at present and will hopefully be finalized by October.

Ms. Duhamel addressed surprise billing issues and the work that is under way to better educate consumers about the issue. The OSI is also considering options for addressing this issue. It is convening a surprise billing forum in September to start the discussion on how to obtain reimbursement for necessary services that are provided out of network but that consumers thought were provided in network. She briefly addressed air ambulance claims and the OSI's efforts to allow regulation of prices.

Members had questions and comments as follows:

- whether the OSI has any authority over network adequacy in Medicaid; no, it does not; the federal government does set standards but gives states flexibility in establishing regulatory oversight of Medicaid managed care plans; California is one model of how this can be done;
- clarification regarding "any willing provider" laws; such laws may give too much ability for providers to demand high reimbursement rates and limit a carrier's ability to negotiate;
- an observation that there are mechanisms to require carriers to give bonus payments to providers in provider shortage areas;
- identification of the opportunity to make Medicaid available to anyone who wants to buy into it;
- recognition that adequacy of durable medical equipment (DME) availability is also important and should be addressed; Medicaid should not have the ability to choose one DME provider, thereby shutting all other DME providers out of the market;
- recognition of the complexity and importance of credentialing requirements by carriers and hospitals for providers;

- differences in carrier approaches to, and compliance with, complaint and grievance procedures; the OSI is planning more education to the public and providers about this; consideration of health literacy is crucial in this effort;
- acknowledgment that early recognition of the role of providers in the complaint and grievance process is important;
- consideration of the potential role of carriers in recruitment and retention of health care providers; and
- issues about who pays what in premiums to ensure that all people have access to an adequate network of providers and carriers; there are inequities in what constitutes a "fair share" of payment.

A brief discussion followed about opportunities to combine and standardize regulation of network adequacy between Medicaid and private insurance.

Recess

The chair recessed the meeting at approximately 5:12 p.m.

Tuesday, July 18

Representative Deborah A. Armstrong reconvened the meeting at 9:11 a.m. Committee members introduced themselves.

Rural Health Care Plan

Senator Ortiz y Pino, Representative Ferrary, Representative Thomson and Jerry N. Harrison, Ph.D., executive director, New Mexico Health Resources (NMHR), were invited to address the committee about a model for rural health care delivery.

Senator Ortiz y Pino described a meeting hosted by the National Conference of State Legislatures, to which several western states were invited, to discuss rural health care challenges and issues. Over the course of the meeting, the New Mexico delegation developed a draft plan for rural health care delivery. The panel intends to further develop the model and get feedback on ideas. Dr. Harrison recognized New Mexico for its leadership in addressing rural health care issues over the years and identified several vital programs. The Rural Primary Health Care Act (RPHCA), a centerpiece for recruitment of providers to rural parts of the state, has had a steady decline in funding. Funding for the Western Interstate Commission for Higher Education program has also declined, limiting the ability of New Mexico students to study at out-of-state institutions for New Mexico tuition rates. New Mexico loan repayment and scholarship programs are similarly shrinking. Without renewed commitment to these programs, efforts at rural health care delivery will continue to be challenged.

Representative Ferrary described some additional ideas identified by the delegation, including ideas to attract more local students to medical school and to develop expanded educational and training opportunities in rural locations. Expansion of primary care training for

primary care physicians, OB/GYNs, pediatricians and others is critical. Exploration of opportunities to match federal and state funding was also discussed.

Representative Thomson noted that the state does not have an overall plan that includes all stakeholders, robust data and recommendations for action. The delegation recognizes the need to identify what it already has, and from that information, create a plan for development of necessary programs for a new rural health plan. The delegation hopes to have a draft by October 15, 2017, with action plans and recommendations. Recommendations may be made to the legislature, state and federal agencies and to other entities, including providers and institutions.

Senator Ortiz y Pino noted that Timothy Lopez, director, Office of Primary and Rural Health, DOH, has been appointed to work with the task force. Mr. Licht has also been invited to join the group as a consultant. Incentives for medical practice in rural health will inevitably include various approaches to tax reform. Graduate medical education will largely focus on residency programs, as was previously mentioned by Mayor Kintigh. It is challenging to expand these programs, as they involve the use of Medicare and Medicaid dollars, which may limit the opportunity to pursue efforts to expand these vital programs. Dr. Harrison explained that there are caps on the amount of Medicaid dollars that can be used for this purpose. Additional waivers may be required in order to expand this educational goal. If the expansion were approved, it would result in a reduction of dollars available to be used for direct services, complicating efforts to utilize Medicaid as an avenue for funding residencies. Without access to Medicaid and Medicare dollars, it is very expensive to expand residency programs. A recent legislative proposal to expand residencies at UNM failed. Dr. Harrison stated that he believes that UNM has funded residencies from existing funds.

Questions and comments by committee members covered the following:

- clarification regarding the recruitment and funding of nine residents at UNM; the first year was funded with state General Fund dollars; UNM funded the remaining two years;
- whether recruitment needs are known and whether efforts are funded for behavioral health; the RPHCA does not provide for or fund recruitment for behavioral health needs; NMHR has funded this need out of its own funds for individuals but not for institutions;
- whether the delegation has included the need for adequate networks in its thinking and planning; it has not specifically done so;
- recognition that preserving the presence of local, independent pharmacies must be included in efforts to address rural health care needs;
- recognition that retention of rural providers is much more difficult than recruitment;
- clarification for realistic expectations regarding the implementation of a rural health plan; hopefully there will be some additional funding available; the DOH and Medicaid will be part of the planning;

- recognition that identification and expansion of incentives will be foundational in addressing rural health care needs;
- recognition that the historical development of mental health care services in New Mexico could serve as a model for rural health care delivery development;
- a suggestion to look at telehealth as part of the solution;
- a call to incorporate real-life experiences and suggestions from rural areas in plan development;
- recognition of the importance of ensuring communication, collaboration and partnerships between and among rural communities;
- encouragement to modernize recruitment and retention methods with greater use of social media; and
- a recommendation that the plan look beyond recruitment and retention of physicians to workforce diversity, immigration, network adequacy, the role of carriers, infrastructure, public health, alternative delivery models and other issues.

Eileen Goode, chief executive officer, New Mexico Primary Care Association (NMPCA), was invited to briefly address the committee about the NMPCA's involvement in, and knowledge of, rural health care needs. She expressed appreciation for the efforts under way and reviewed the utilization trends in federally qualified health centers (FQHCs), highlighting the locations of clinics and practitioners in rural New Mexico. NMPCA members employ 1,172 clinicians statewide. Ms. Goode offered to work with the delegation in the development of the plan.

Valerie Puccini, licensed independent clinical social worker, suggested ways to improve access to behavioral health services in New Mexico. She identified some opportunities for structural changes that could be made, including at FQHCs. A niche market exists with independent practitioners, such as herself, who could improve access, but that would require modest regulatory changes. Independent social workers would like to be involved in the process.

Mayor Kintigh was invited to make additional observations. He strongly recommended direct representation of stakeholders from rural communities.

School-Based Health Centers (SBHCs) Update

Nancy Rodriguez, executive director, New Mexico Alliance for School-Based Health Care, introduced herself to the committee, mentioning the similarity between her name and committee member Senator Nancy Rodriguez. Ms. Rodriguez provided information about the alliance and ways she believes child health outcomes can be improved in New Mexico. The model for school-based health care involves integrated primary and behavioral health care at all sites in New Mexico. All SBHCs bill for services through Medicaid and private insurance, as well as receiving some DOH funding support. Financial stability for the centers is fragile. Some services, such as behavioral health and reproductive services, are confidential and cannot be billed. SBHCs provide primary care for students and often are the only primary care provider in that community. Health literacy is a focus of SBHCs and is foundational in helping young people not only to manage their own health care needs as they grow, but often inspiring students

to go into medical professions. SBHCs help families who otherwise might not have the ability to get their children to medical care and help address provider shortages in rural communities. Some SBHCs are also available to families and staff of schools. Use of telehealth in SBHCs is growing. Ms. Rodriguez reviewed the history of the development of school-based health care in New Mexico, including the growth of the number of clinics over time. She described the effects of varying levels of funding on school-based health, providing specific results of funding on care. There are now 70 SBHCs across New Mexico.

Ms. Rodriguez identified opportunities and challenges for SBHCs in the areas of substance abuse screening and services, teen pregnancy and reproductive health services. Funding stability and growth would greatly improve not only the availability of health care services to youth, but also health outcomes, especially in rural areas.

Tillie Crawford, La Casa Family Health Care, provided personal testimony on her six-year experience with an SBHC in Roswell.

Questions and comments from committee members addressed the following:

- steps a school or school board must take to establish and sustain an SBHC in its community;
- clarification regarding the interface between SBHCs and the Public Education Department;
- the importance of sufficient funding to augment availability of these critical services;
- whether there are waiting lists to establish new SBHCs; there is no official waiting list; however, DOH contracts are generally only made available about once every 18 months;
- clarification regarding reimbursement for sports physicals; reimbursement can only occur if the physical occurs concurrently with a well-child check;
- circumstances under which Medicaid can be billed; there are inconsistencies;
- issues regarding confidentiality in circumstances of rape; all SBHCs are mandatory reporters in those circumstances; and
- whether prenatal care is provided at SBHCs; it varies depending on the community and who sponsors the center.

Public Comment

Don Bateman made comments on behalf of AARP. He noted that SBHCs and rural health care clinics are also of help to grandparents raising grandchildren.

DOH Facilities Update

Gabrielle Sanchez-Sandoval, Esq., deputy director, DOH, was joined by George Morgan, director, Facilities Management Division, General Services Department, and Roberta Vigil, fiscal officer, DOH. Ms. Sanchez-Sandoval provided an overview and update on DOH facilities and community programs in New Mexico, including the locations of the specific state-run facilities,

the services offered and the populations served at each. She noted that the facilities provide safety net services to persons who otherwise might not or would not have access to care. All facilities are created by New Mexico statutes. She offered site-specific information on the New Mexico State Veterans' Home, the New Mexico Behavioral Health Institute at Las Vegas, Turquoise Lodge, Fort Bayard Medical Center, Sequoyah Adolescent Treatment Center, the Los Lunas Community Program and the New Mexico Rehabilitation Center. Future initiatives include assessments related to staff injuries; cost containment and alignment of service provision with legal requirements, financial capacity and community need; exploring efficiencies with "bundled" purchases and endeavors, such as electronic health records, pharmacy coverage and billing; and nursing and staff recruitment.

Questions and comments from committee members were as follows:

- questions regarding the impact of the closure of Yucca Lodge; there were no patients there at the time of the transfer;
- questions regarding the use of unlicensed providers of nursing services in certain circumstances; this is a practice that is supervised by the Board of Nursing and has been going on for some time;
- whether state facilities help to serve individuals with addictions or mental illness who are experiencing a violent outbreak; Turquoise Lodge can admit some of these individuals; admission now occurs within three days;
- a statement of the importance of state facilities' readiness to provide addiction services when the addicted person is ready to receive them and not be hampered by staff shortages;
- clarification regarding the closure of Yucca Lodge and what happened to the patients at the time; it was not full, but there were patients there; many patients chose to remain in the community rather than transfer to another facility;
- questions regarding the New Mexico Rehabilitation Center in Roswell; it provides medical as well as social rehabilitation;
- questions regarding how many veterans are receiving services at the New Mexico Rehabilitation Center; none at the moment; capital outlay funds as well as some revisions to the model and other transitions are needed; ultimately, the facility will offer a full range of addiction services;
- clarification of whether adolescents may be treated in addition to adults at Turquoise Lodge; that is not part of the plan;
- clarification regarding the number of people currently being served at Turquoise Lodge; the average daily census is 14 of 15 detox beds are full and 13 of 16 rehabilitation beds are full;
- clarification of facilities for individuals with developmental disabilities; there is one state-run facility, but there are numerous other facilities with which the state contracts; the state facility is intended to serve developmentally disabled individuals who are sex offenders and are court ordered for placement;

- a request for an update on building renovations at Meadows, the long-term care facility at the New Mexico Behavioral Health Institute at Las Vegas; renovations are under way; an appropriation has been received and the project is out for bids;
- questions regarding the clientele at Meadows; there are some clients who are indigent but not eligible for Medicaid and some who have behavioral health issues;
- a request for future testimony about the long-term effectiveness of treatment for adolescent sex offenders;
- whether the DOH would be open to the idea of establishing a facility for aging, incarcerated individuals, if funding were to be available; the DOH would be open to the conversation;
- a question of whether DOH facilities are receiving discounts under Section 340B of the federal Public Health Service Act that are administered by the federal Health Resources and Services Administration; no, but they will investigate;
- encouragement for the DOH to partner with the Corrections Department to enhance efficiencies, especially regarding drug prices;
- encouragement to expand services to adolescents; the need in New Mexico is enormous;
- a question regarding the time line for transition of the veterans' home from the DOH to the Veterans' Services Department; operationally, it is already complete; the formal agreement is for one year to handle all details;
- encouragement for the DOH to not exit prematurely, as the DOH has medical expertise, while the Veterans' Services Department has none; and
- whether the DOH is working with the HSD on interoperability of information technology systems; yes, they are working closely together.

Tour of New Mexico Rehabilitation Center

Committee members visited the New Mexico Rehabilitation Center, where they received information about the services provided there.

Adjournment

Following the tour, the meeting was adjourned at 3:30 p.m.